FIG. 1 A

TEMPLATE SELECTION GUIDE

		270 Back, Hip, Knee Neck, Shoulder	272 Elbow, Wrist, Hand Ankle, Foot	274 Fingers, Toes and Contusions
250	New problem, presentation suggests work - up needed	Level 4 New	Level 3 New	Level 2 New
252	New problem, no work - up needed plus 1 or more established problems	Level 4 New	Level 3 New	Level 2 New
254	New problem, no work - up, no other established problems	Level 3 New	Level 3 New	Level 2 New
256	Established problem worsening with 1 or more stable problems	Level 4 Established	Level 3 Established	Level 2 Established
258	Established problem stable with 2 or more other stable problems	Level 4 Established	Level 3 Established	Level 2 Established
260	Established problem stable with 1 other stable problem X-rays & prescription medications needed	Level 4 Established	Level 3 Established	Level 2 Established
262	Established problem stable with no or 1 other stable problem, no X - rays or prescription medications needed	Level 3 Established	Level 3 Established	Level 2 Established

LEVEL 5 If all criteria for level 4 met plus any of the following:

1. Abrupt change in neurological status;
2. Problem potentially threatens life or body function;
3. Invasive tests needed such as myelogram, discogram;
4. Elective surgery needed with identified risk factors; and
5. Emergency surgery or drug therapy needing intensive monitoring or parenteral pain medication.

LEVEL 1 If problem minimal and needs physician supervision but only minimal direct involvement.

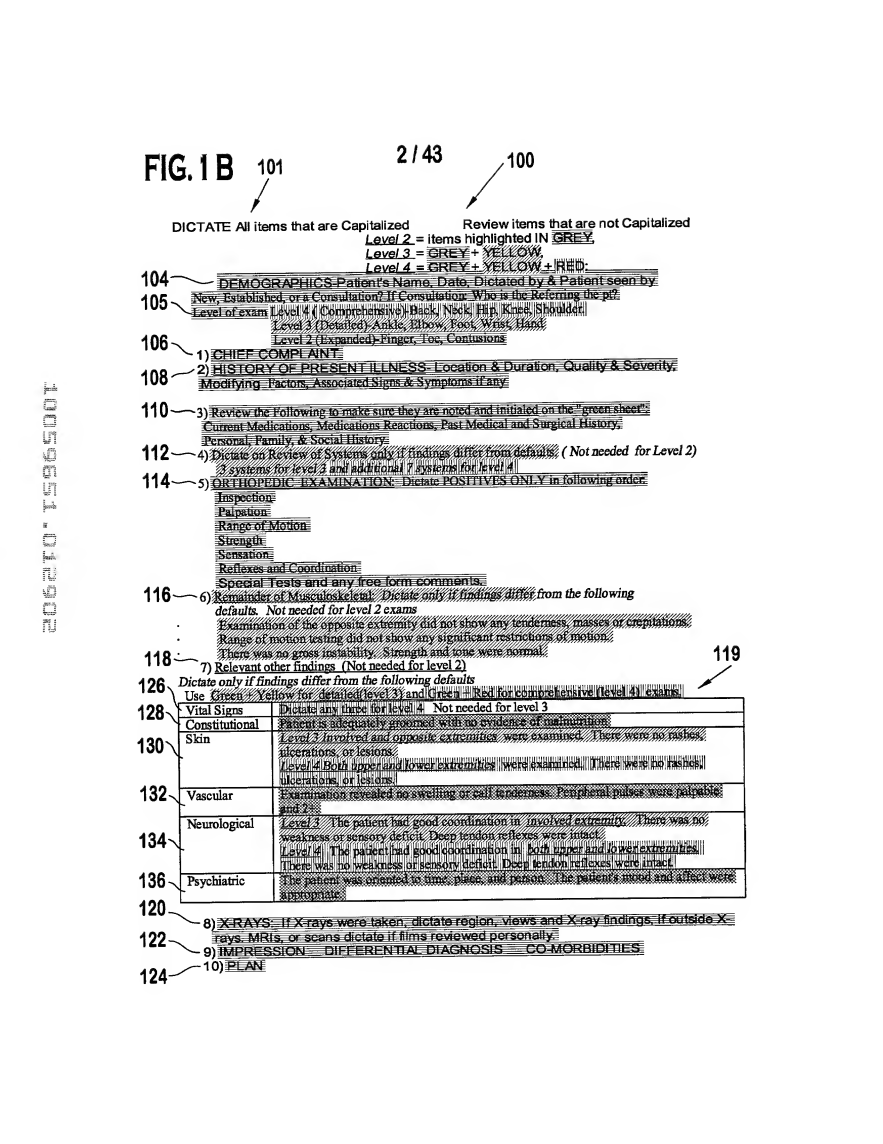
CONSULT - Must meet following 3 tests:

1. Opinion must be requested by another provider;
2. Request for consult must be documented in the patient's chart; and
3. Written report of findings must be sent back to the requesting provider.

Consults can be:

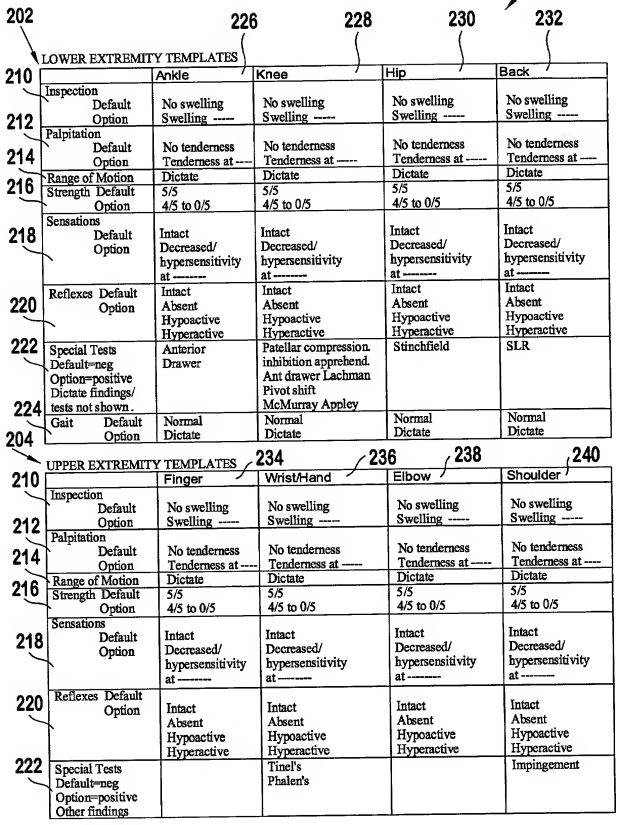
1. Followed by treatment;
2. Requested by members of the same group; or
3. Requested by ER physician.

FIG. 1 B



Vital Signs	Dictate any three for level 4. Not needed for level 3
Constitutional	Patient is adequately groomed with no evidence of malnutrition.
Skin	*Level 3 Involved and opposite extremities* were examined. There were no rashes, ulcerations, or lesions. *Level 4* Both upper and lower extremities were examined. There were no rashes, ulcerations, or lesions.
Vascular	Examination revealed no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological	*Level 3* The patient had good coordination in *involved extremity*. There was no weakness or sensory deficit. Deep tendon reflexes were intact. *Level 4* The patient had good coordination in both upper and lower extremities. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric	The patient was oriented to time, place, and person. The patient's mood and affect were appropriate.

FIG. 1 C



LOWER EXTREMITY TEMPLATES

	Ankle	Knee	Hip	Back
Inspection Default	No swelling	No swelling	No swelling	No swelling
Option	Swelling -----	Swelling -----	Swelling -----	Swelling -----
Palpitation Default	No tenderness	No tenderness	No tenderness	No tenderness
Option	Tenderness at ----	Tenderness at -----	Tenderness at -----	Tenderness at ----
Range of Motion	Dictate	Dictate	Dictate	Dictate
Strength Default	5/5	5/5	5/5	5/5
Option	4/5 to 0/5	4/5 to 0/5	4/5 to 0/5	4/5 to 0/5
Sensations Default	Intact	Intact	Intact	Intact
Option	Decreased/ hypersensitivity at --------	Decreased/ hypersensitivity at --------	Decreased/ hypersensitivity at --------	Decreased/ hypersensitivity at --------
Reflexes Default	Intact	Intact	Intact	Intact
Option	Absent Hypoactive Hyperactive	Absent Hypoactive Hyperactive	Absent Hypoactive Hyperactive	Absent Hypoactive Hyperactive
Special Tests Default=neg Option=positive Dictate findings/ tests not shown.	Anterior Drawer	Patellar compression. inhibition apprehend. Ant drawer Lachman Pivot shift McMurray Appley	Stinchfield	SLR
Gait Default	Normal	Normal	Normal	Normal
Option	Dictate	Dictate	Dictate	Dictate

UPPER EXTREMITY TEMPLATES

	Finger	Wrist/Hand	Elbow	Shoulder
Inspection Default	No swelling	No swelling	No swelling	No swelling
Option	Swelling -----	Swelling -----	Swelling -----	Swelling -----
Palpitation Default	No tenderness	No tenderness	No tenderness	No tenderness
Option	Tenderness at ----	Tenderness at -----	Tenderness at -----	Tenderness at ----
Range of Motion	Dictate	Dictate	Dictate	Dictate
Strength Default	5/5	5/5	5/5	5/5
Option	4/5 to 0/5	4/5 to 0/5	4/5 to 0/5	4/5 to 0/5
Sensations Default	Intact	Intact	Intact	Intact
Option	Decreased/ hypersensitivity at --------	Decreased/ hypersensitivity at --------	Decreased/ hypersensitivity at --------	Decreased/ hypersensitivity at --------
Reflexes Default	Intact	Intact	Intact	Intact
Option	Absent Hypoactive Hyperactive	Absent Hypoactive Hyperactive	Absent Hypoactive Hyperactive	Absent Hypoactive Hyperactive
Special Tests Default=neg Option=positive Other findings		Tinel's Phalen's		Impingement

FIG. 2

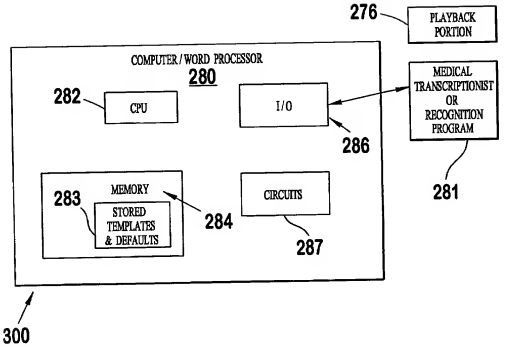


FIG. 3

Billing and payment process for a medical service

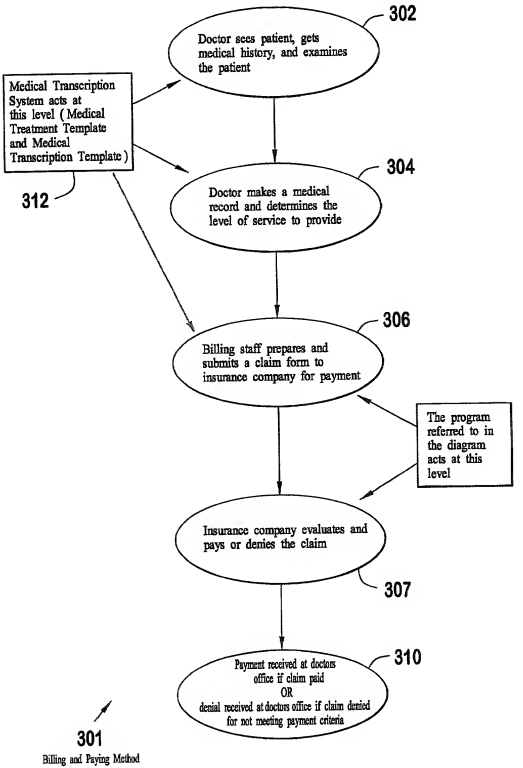


FIG. 4

101 exam level portion

LEVEL 2 (EXPANDED) 105

First Verify the Level of exam - Level 2 (Expanded) - Finger, Toe, Contusions.

DICTATE THE FOLLOWING ITEMS HIGHLIGHTED

104 DEMOGRAPHICS - DICTATE Patient's Name, Date, Dictated by & Patient seen by New, Established, or a Consultation? If Consultation: Who is Referring the patient?

106 1) CHIEF COMPLAINT: DICTATE CHIEF COMPLAINT.

108 2) HISTORY OF PRESENT ILLNESS: DICTATE at least 2 of the following- Location, Duration, Quality & Severity, Modifying Factors, any Associated Signs & Symptoms.

110 3) Review and Initial (DO NOT DICTATE). the Following to make sure they are noted and initialed on the "intake sheet":
Current Medications, Medications Reactions, Past Medical and Surgical History, Personal, Family, & Social History.

112 4) REVIEW OF SYSTEMS. (Review, initial and date intake sheet) Only need to comment on musculo skeletal system if positive. Do not need to comment on other systems even if positive.

114 5) ORTHOPAEDIC EXAMINATION: Dictate POSITIVES ONLY in following order:
Inspection;
Palpation;
Range of Motion;
Strength;
Sensation;
Reflexes and Coordination; and
Special Tests and any free form comments.

NOTE: There are no Sections 6) and 7) for Level 2 Exams

120 8) X-RAYS: If X-rays were taken, DICTATE X-Ray Findings, if outside X-rays. MRI or scans dictate if films reviewed personally

122 9) IMPRESSION: DICTATE IMPRESSION

124 10) PLAN: DICTATE PLAN

FIG. 5

101 exam level portion

LEVEL 3 (DETAILED)

First Verify the Level of exam - Level 3 (Detailed) - Ankle, Elbow, Foot, Wrist, Hand. 105

DICTATE THE FOLLOWING ITEMS HIGHLIGHTED

104 DEMOGRAPHICS - DICTATE Patient's Name, Date, Dictated by & Patient seen by New, Established, or a Consultation? If Consultation: Who is Referring the patient?

106 1) CHIEF COMPLAINT: DICTATE CHIEF COMPLAINT.

108 2) HISTORY OF PRESENT ILLNESS: DICTATE at least 2 of the following- Location, Duration, Quality & Severity, Modifying Factors, any Associated Signs & Symptoms.

110 3) Review and Initial (DO NOT DICTATE). the Following to make sure they are noted and initialed on the "intake sheet":
Current Medications, Medications Reactions, Past Medical and Surgical History, Personal, Family, & Social History.

112 4) REVIEW OF SYSTEMS. (Review, initial and date intake sheet) Dictate only systems with positive boxes checked-do not dictate systems with negative boxes checked.

114 5) ORTHOPAEDIC EXAMINATION: Dictate POSITIVES ONLY in following order:
Inspection,
Palpation,
Range of Motion; MUST DICTATE RANGE OF MOTION;
Strength,
Sensation,
Reflexes and Coordination, and
Special Tests and any free form comments.

116 6) Remainder of Musculoskeletal: *Dictate only if findings differ from the following defaults. Do not dictate if exam findings are negative or normal.*
- Examination of the opposite extremity did not show any tenderness, masses or crepitations.
- Range of motion testing did not show any significant restrictions of motion.
- There was no gross instability. Strength and tone were normal.

118 7) Relevant other findings Dictate only if findings differ from the following *defaults. Do not dictate if exam findings are negative or normal.* 119

128	Constitutional	Patient is adequately groomed with no evidence of malnutrition
130	Skin	*Involved and opposite extremity* were examined. There were no rashes, ulcerations, or lesions.
132	Vascular	Examination revealed no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
134	Neurological	The patient had good coordination in *involved extremity*. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
136	Psychiatric	The patient was oriented to time, place, and person. The patient's mood and affect were appropriate.

120 8) X-RAYS: If X-rays were taken, DICTATE X-Ray Findings, if outside X-rays. MRI or scans dictate if films reviewed personally

122 9) IMPRESSION: DICTATE IMPRESSION Differential Diagnosis /Co-Morbidities DICTATE THESE IF RELEVANT.

124 10) PLAN: DICTATE PLAN

FIG. 6

101 exam level portion

LEVEL 4 COMPREHENSIVE

First Verify the Level of exam - Level 4 (Comprehensive) - Back, Neck, Hip, Knee, Shoulder. 105

DICTATE THE FOLLOWING ITEMS HIGHLIGHTED

104 DEMOGRAPHICS - DICTATE Patient's Name, Date, Dictated by & Patient seen by New, Established, or a Consultation? If Consultation: Who is Referring the patient?

106 1) CHIEF COMPLAINT: DICTATE CHIEF COMPLAINT.

108 2) HISTORY OF PRESENT ILLNESS: DICTATE at least 2 of the following- Location, Duration, Quality & Severity, Modifying Factors, any Associated Signs & Symptoms.

110 3) Review and Initial (DO NOT DICTATE). the Following to make sure they are noted and initialed on the "intake sheet":
Current Medications, Medications Reactions, Past Medical and Surgical History, Personal, Family, & Social History.

112 4) REVIEW OF SYSTEMS. (Review, initial and date intake sheet) Dictate only systems with positive boxes checked-do not dictate systems with negative boxes checked.
all 10 systems boxes need to be reviewed for level 4

114 5) ORTHOPAEDIC EXAMINATION: Dictate POSITIVES ONLY in following order:
Inspection;
Palpation;
Range of Motion; MUST DICTATE RANGE OF MOTION
Strength;
Sensation;
Reflexes and Coordination; and
Special Tests and any free form comments.

116 6) Remainder of Musculoskeletal: *Dictate only if findings differ from the following defaults. Do not dictate if exam findings are negative or normal.*
- Examination of the opposite extremity did not show any tenderness, masses or crepitations.
- Range of motion testing did not show any significant restrictions of motion.
- There was no gross instability. Strength and tone were normal.

118 7) Relevant other findings Dictate only if findings differ from the following defaults. *Do not dictate if exam findings are negative or normal. Dictate Vital signs as shown.* 119

126

128	Vital Signs	DICTATE ANY THREE
	Constitutional	Patient is adequately groomed with no evidence of malnutrition
130	Skin	*Both upper and lower extremities* were examined. There were no rashes, ulcerations, or lesions.
132	Vascular	Examination revealed no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
134	Neurological	The patient had good coordination in *both upper and lower extremities.* There was no weakness or sensory deficit. Deep tendon reflexes were intact.
136	Psychiatric	The patient was oriented to time, place, and person. The patient's mood and affect were appropriate.

120 8) X-RAYS: If X-rays were taken, DICTATE X-Ray Findings, if outside X-rays. MRI or scans dictate if films reviewed personally

122 9) IMPRESSION: DICTATE IMPRESSION. Differential Diagnosis /Co-Morbidities DICTATE AT LEAST 1 DIFFERENTIAL OR 1 CO-MORBIDITY, MORE IF RELEVANT.

124 10) PLAN: DICTATE PLAN

NEW PATIENT-COMPREHENSIVE KNEE EXAM

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
402 **FAMILY/RE. PHYS:** Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med} Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions} Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Social History:**
Personal, Family, and {Notes:Event 4} Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Eyes, Ears, & Nose:	Non Contributory
Throat & Mouth:	Patient denies sore throat.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Respiratory:	Patient denies coughing or wheezing.
Gastrointestinal:	Non Contributory
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Integumentary:	Patient denies any rashes or skin ulcers.
Neurological:	Patient denies any weakness or loss or coordination.
Psychiatric:	Patient denies feeling depressed or anxious.

400

FIG. 7A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **EXAMINATION:**

Inspection:	Inspection of the knee reveals {Swelling:no swelling}.
Deformity:	There is {Deformity:no deformity present...}
Palpation:	Palpation of the knee reveals {Palpation .no tenderness}
Effusion:	There is {Effusion:no effusion present}.
ROM:	{Miscellaneous:Free Form}
Strength Testing:	The strength in the quadriceps is {Strength.:5/5}
Sensation:	The sensation of the lower extremities appears to be {Sensation:. intact}
Reflexes:	The deep tendon reflexes including the patellar and achilles are {Reflexes intact }
Gait:	{Miscellaneous:Free Form}

418 — **ADDITIONAL TEST**

The following special tests were performed and the results of these tests are summarized as:

Patellar Tracking:	{Negative:Negative}
Patellar Compression:	{Negative:Negative}
Patellar Apprehension:	{Negative :Negative}
Lachman-Anterior Drawer:	{Negative:Negative}
Pivot-Shift Test:	{Negative:Negative}
McMurray:	{Negative:Negative}
Apley Test:	{Negative:Negative}

400

FIG. 7B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

420 — **Relevant Other Findings:**

Vital Signs:	{Miscellaneous:Free Form}
Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations. Range of motion testing did not show any significant restrictions of motion. There was no gross instability. Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**

Impression:	{Miscellaneous:Free Form}
Differential Diagnoses:	{Miscellaneous:Free Form}
Co-Morbidities Noted:	{Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

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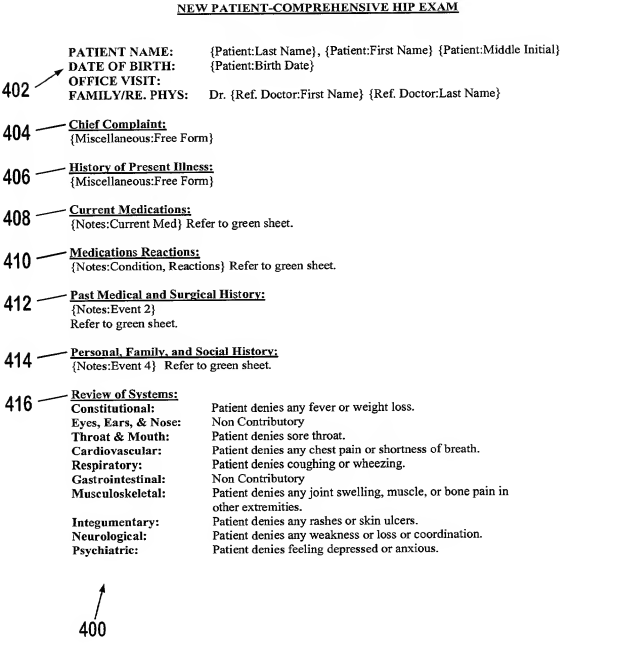
FIG. 7C



NEW PATIENT-COMPREHENSIVE HIP EXAM

402
PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
FAMILY/RE. PHYS: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med} Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions} Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4} Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Eyes, Ears, & Nose:	Non Contributory
Throat & Mouth:	Patient denies sore throat.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Respiratory:	Patient denies coughing or wheezing.
Gastrointestinal:	Non Contributory
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Integumentary:	Patient denies any rashes or skin ulcers.
Neurological:	Patient denies any weakness or loss or coordination.
Psychiatric:	Patient denies feeling depressed or anxious.

400

FIG. 8A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **EXAMINATION:**

Inspection:	Inspection of the hip are reveals {Swelling:no swelling}.
Palpation:	Palpation of the hip reveals {Palpation .no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength in flexion, abduction, adduction, internal and external rotation appears to be {Strength.:5/5}
Sensation:	The sensation lower extremities appears to be {Sensation:.intact}
Reflexes:	The deep tendon reflexes including the patellar and achilles are {Reflexes .intact}
Special Test/ Stability:	{Miscellaneous:Free Form}
Gait:	{Miscellaneous:Free Form}

420 — **Relevant Other Findings:**

Vital Signs:	{Miscellaneous:Free Form}
Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

400

FIG. 8B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations.
Range of motion testing did not show any significant restrictions of motion.
There was no gross instability.
Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}
Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 8C

NEW PATIENT-DETAILED ELBOW EXAM

402

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Neurological:	Patient denies any weakness or loss or coordination.

400

FIG. 9A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 **Examination:**

Inspection:	Inspection reveals {Swelling of the elbow.
Palpation:	Palpation of the elbow reveals {Palpation .no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength with flexionlextension is {Strength:.5/5}
Sensation:	Sensation of the upper extremity appears to be {Sensation:.intact}
Reflexes:	The deep tendon reflexes including the brachioradialis, biceps/triceps are {Reflexes .intact }
Special Test/ Stability:	{Miscellaneous:Free Form}

420 **Relevant Other Findings:**

Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

400

FIG. 9B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations.
Range of motion testing did not show any significant restrictions of motion.
There was no gross instability.
Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 9C

NEW PATIENT-EXPANDED FINGER EXAM

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
402 **OFFICE VISIT:**
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**
Constitutional: Patient is adequately groomed with no evidence of malnutrition or body habitus.
Skin: The involved extremity was examined. There were no rashes, ulcerations, or lesion. No nodules or abnormal retraction was noted.

400

FIG. 10A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 **EXAMINATION:**

Inspection:	Inspection reveals of the finger {Swelling .no swelling}
Palpation:	Palpation of the finger reveals {Palpation .no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Grip Strength is {Strength:. Strength of the finger flexor and extensors is {Strength:.5/5}
Sensation:	The light touch sensation appears to be {Sensation:.intact}
Reflexes:	Reflexes in the involved extremity are {Reflexes .intact}
Special Test/ Other Findings:	{Miscellaneous:Free Form}

424 **X-Rays:**
{Miscellaneous:Free Form}

426 **Assessment:**

Impression:	{Miscellaneous:Free Form}
Differential Diagnoses:	{Miscellaneous:Free Form}
Co-Morbidities Noted:	{Miscellaneous:Free Form}

428 **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 10B

NEW PATIENT-DETAILED FOOT EXAM

402

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Neurological:	Patient denies any weakness or loss or coordination.

400

FIG. 11A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **Examination:**

Inspection:	Inspection reveals {Swelling of the foot.;}
Palpation:	Palpation of the foot reveals {Palpation .no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength of the flexor and extensor is {Strength:.5/5}
Sensation:	Sensation of the foot appears to be {Sensation:intact}
Reflexes:	The deep tendon reflexes including the patellar and achilles are {Reflexes.intact }
Coordination:	Coordination appears to be intact.
Special Test/ Stability:	
Gait:	{Miscellaneous:Free Form}

420 — **Relevant Other Findings:**

Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations. Range of motion testing did not show any significant restrictions of motion. There was no gross instability. Strength and tone were normal.

400

FIG. 11B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 11C

NEW PATIENT-DETAILED ANKLE EXAM

402

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Neurological:	Patient denies any weakness or loss or coordination.

400

FIG. 12A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **Examination:**

Inspection:	Inspection reveals {Swelling of the ankle.
Palpation:	Palpation of the ankle reveals {Palpation .no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength testing reveals strength of the ankle dorsi and plantar flexors to be {Strength:5/5}
Sensation:	The sensation in the foot appears to be {Sensation:.intact}
Reflexes:	The deep tendon reflexes including the achilles are {Reflexes .intact}
Special Test/ Stability:	Anterior Drawer test is {Miscellaneous:Free Form} The mortise appears to be stable.

420 — **Relevant Other Findings:**

Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

400

FIG. 12B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations. Range of motion testing did not show any significant restrictions of motion. There was no gross instability. Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 12C

NEW PATIENT-COMPREHENSIVE SHOULDER EXAM

402
PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Eyes, Ears, & Nose:	Non Contributory
Throat & Mouth:	Patient denies sore throat.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Respiratory:	Patient denies coughing or wheezing.
Gastrointestinal:	Non Contributory
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Integumentary:	Patient denies any rashes or skin ulcers.
Neurological:	Patient denies any weakness or loss or coordination.
Psychiatric:	Patient denies feeling depressed or anxious.

400

FIG. 13A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **Examination:**

Inspection:	Inspection of the shoulder reveal {Swelling:no swelling}
Palpation:	Palpation of the shoulder reveals {Palpation.no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength of the shoulder in flexion and abduction is {Strength.:5/5}
Sensation:	The sensation of the upper extremity appears to be {Sensation:.intact}
Reflexes:	The deep tendon reflexes including the bicep, tricep, and brachioradialis are {Reflexes .intact}
Impingement Test:	Impingement sign is {Negative:Negative}
Other Special Test:	Special tests including Yergason's, drop-arm, apprehension are negative.

420 — **Relevant Other Findings:**

Vital Signs:	{Miscellaneous:Free Form}
Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

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FIG. 13B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations.
Range of motion testing did not show any significant restrictions of motion.
There was no gross instability. Strength and tone were normal.

424 **X-Rays:**
{Miscellaneous:Free Form}

426 **Assessment:**

Impression:	{Miscellaneous:Free Form}
Differential Diagnoses:	{Miscellaneous:Free Form}
Co-Morbidities Noted:	{Miscellaneous:Free Form}

428 **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 13C

NEW PATIENT-DETAILED SHOULDER EXAM

402

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Neurological:	Patient denies any weakness or loss or coordination.

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FIG. 14A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **Examination:**

Inspection:	Inspection of the shoulder reveals {Swelling:no swelling}
Palpation:	Palpation of the shoulder reveals {Palpation.no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength of the shoulder in flexion and abduction is {Strength.:5/5}
Sensation:	The sensation of the upper extremity appears to be {Sensation:.intact}
Reflexes:	The deep tendon reflexes including the bicep, tricep, and brachioradialis are {Reflexes .intact}
Impingement Test:	Impingement sign is {Negative:Negative}
Other Special Test:	Special tests including Yergason's, drop-arm, apprehension are negative.

420 — **Relevant Other Findings:**

Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

400

FIG. 14B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations. Range of motion testing did not show any significant restrictions of motion. There was no gross instability. Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 14C

NEW PATIENT-DETAILED KNEE EXAM

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
402 **OFFICE VISIT:**
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**
Constitutional: Patient denies any fever or weight loss.
Musculoskeletal: Patient denies any joint swelling, muscle, or bone pain in other extremities.
Cardiovascular: Patient denies any chest pain or shortness of breath.
Neurological: Patient denies any weakness or loss or coordination.

400

FIG. 15A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 **Examination:**

Inspection:	Inspection of the knee reveals {Swelling:no swelling}.
Deformity:	There is {Deformity:no deformity present...}
Palpation:	Palpation of the knee reveals {Palpation.no tenderness}
Effusion:	There is {**Effusion:**no effusion present}.
ROM:	{Miscellaneous:Free Form}
Strength Testing:	The strength in the quadriceps is { Strength.: 5/5}
Sensation:	The sensation of the lower extremities appears to be {Sensation:intact}
Reflexes:	The deep tendon reflexes including the patellar and achilles are {Reflexes:intact}
Gait:	{Miscellaneous:Free Form}

418 **ADDITIONAL TEST**

The following special tests were performed and the results of these tests are summarized as:

Patellar Tracking:	{Negative:Negative}
Patellar Compression:	{Negative:Negative}
Patellar Apprehension:	{Negative:Negative}
Lachman-Anterior Drawer:	{Negative:Negative}
Pivot-Shift Test:	{Negative:Negative}
McMurray:	{Negative:Negative}
Apley Test:	{Negative:Negative}

400

FIG. 15B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

420 — **Relevant Other Findings:**

Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations. Range of motion testing did not show any significant restrictions of motion. There was no gross instability. Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**

Impression:	{Miscellaneous:Free Form}
Differential Diagnoses:	{Miscellaneous:Free Form}
Co-Morbidities Noted:	{Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 15C

NEW PATIENT-COMPREHENSIVE BACK EXAM

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
402 **OFFICE VISIT:**
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}

404 **Chief Complaint:**
{Miscellaneous:Free Form}

406 **History of Present Illness:**
{Miscellaneous:Free Form}

408 **Current Medications:**
{Notes:Current Med}
Refer to green sheet.

410 **Medications Reactions:**
{Notes:Condition, Reactions}
Refer to green sheet.

412 **Past Medical and Surgical History:**
{Notes:Event 2}
Refer to green sheet.

414 **Personal, Family, and Social History:**
{Notes:Event 4}
Refer to green sheet.

416 **Review of Systems:**

Constitutional:	Patient denies any fever or weight loss.
Eyes, Ears, & Nose:	Non Contributory
Throat & Mouth:	Patient denies sore throat.
Cardiovascular:	Patient denies any chest pain or shortness of breath.
Respiratory:	Patient denies coughing or wheezing.
Gastrointestinal:	Non Contributory
Musculoskeletal:	Patient denies any joint swelling, muscle, or bone pain in other extremities.
Integumentary:	Patient denies any rashes or skin ulcers.
Neurological:	Patient denies any weakness or loss or coordination.
Psychiatric:	Patient denies feeling depressed or anxious.

400

FIG. 16A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 **Examination:**

Inspection:	Inspection of the back reveal {Swelling:no swelling}
Palpation:	Palpation of the back reveals {Palpation.no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength of the lower extremities include hip flexors, quad strength, hip adductors, and abductors is {Strength. Specifically strength in EHL, FHL is {Strength:5/5}
Sensation:	The sensation in the lumbrosacral area, gluteal region and lower extremities are appears to be {Sensation:.intact}
Reflexes:	The deep tendon reflexes including the patellar and achilles are {Reflexes.intact}
Coordination:	Tip-toes walk and heel walking are normal.
Special Test/	
Stability:	{Miscellaneous:Free Form}
Gait:	{Miscellaneous:Free Form}

420 **Relevant Other Findings:**

Vital Signs:	{Miscellaneous:Free Form}
Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

400

FIG. 16B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations.
Range of motion testing did not show any significant restrictions of motion.
There was no gross instability. Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 16C

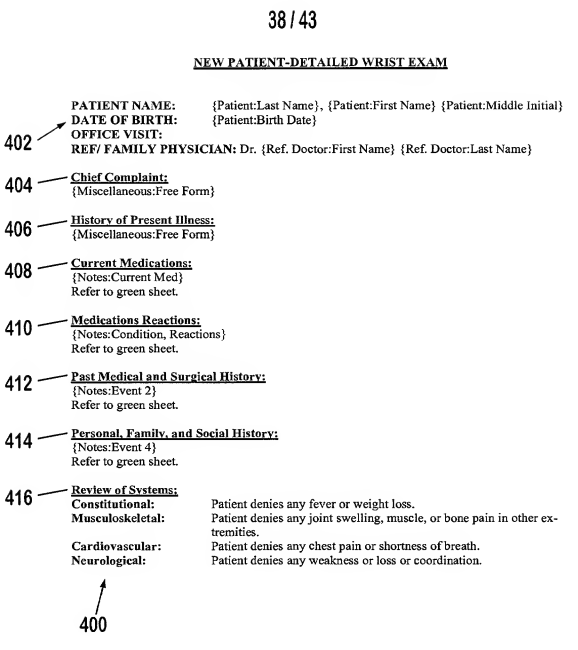
NEW PATIENT-DETAILED WRIST EXAM
PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:
REF/ FAMILY PHYSICIAN: Dr. {Ref. Doctor:First Name} {Ref. Doctor:Last Name}
402
Chief Complaint:
{Miscellaneous:Free Form}
404
History of Present Illness:
{Miscellaneous:Free Form}
406
Current Medications:
{Notes:Current Med}
Refer to green sheet.
408
Medications Reactions:
{Notes:Condition, Reactions}
Refer to green sheet.
410
Past Medical and Surgical History:
{Notes:Event 2}
Refer to green sheet.
412
Personal, Family, and Social History:
{Notes:Event 4}
Refer to green sheet.
414
Review of Systems:
416
Constitutional: Patient denies any fever or weight loss.
Musculoskeletal: Patient denies any joint swelling, muscle, or bone pain in other extremities.
Cardiovascular: Patient denies any chest pain or shortness of breath.
Neurological: Patient denies any weakness or loss or coordination.
400

FIG. 17A

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

417 — **Examination:**

Inspection:	Inspection reveals {Swelling of the wrist.}
Palpation:	Palpation of the wrist reveals {Palpation .no tenderness}
ROM:	{Miscellaneous:Free Form}
Strength Testing:	Strength of wrist flexors, extensors, radial and ulnar deviators, supinators and pronators is {Strength:.5/5}
Sensation:	The light touch sensation appears to be {Sensation..intact}
Reflexes:	The reflexes in the involved extremity are {Reflexes .intact}
Tinel's Test:	{Miscellaneous:Free Form}
Phalen's Test:	{Miscellaneous:Free Form}
Other findings if any:	{Miscellaneous:Free Form}

420 — **Relevant Other Findings:**

Constitutional:	Patient is adequately groomed with no evidence of malnutrition.
Skin:	Involved and opposite extremity were examined. There were no rashes, ulcerations, or lesion.
Vascular:	Examination reveals no swelling or calf tenderness. Peripheral pulses were palpable and 2+.
Neurological:	The patient had good coordination in involved extremity. There was no weakness or sensory deficit. Deep tendon reflexes were intact.
Psychiatric:	The patient was oriented to time, place, and person. The patient's mood and affect was appropriate.

400

FIG. 17B

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
OFFICE VISIT:

422 — **Remainder of Musculoskeletal:**
Examination of the opposite extremity did not show any tenderness, masses or crepitations. Range of motion testing did not show any significant restrictions of motion. There was no gross instability. Strength and tone were normal.

424 — **X-Rays:**
{Miscellaneous:Free Form}

426 — **Assessment:**
Impression: {Miscellaneous:Free Form}
Differential Diagnoses: {Miscellaneous:Free Form}
Co-Morbidities Noted: {Miscellaneous:Free Form}

428 — **Plan:**
{Miscellaneous:Free Form}

Dictated by: {Physician/PA List:Thomas S. Smith, M.D...}

Patient seen by: {Physician/PA List:Thomas S. Smith, M.D...}

400

FIG. 17C

{Miscellaneous:Today's Date}

RE: {Patient:First Name} {Patient:Last Name}

TO WHOM IT MAY CONCERN:

This is to state that {Patient:First Name} {Patient:Last Name} is under my care for severe degenerative joint disease of the {Miscellaneous:Free Form}. This has been confirmed by x-ray evaluation.

The patient has been tried on medication and other modalities which have failed to relieve {His/Her:his} discomfort. At this point in time, it is recommended that {He/She:he} have 3 Synvisc injections into the {Miscellaneous:Free Form}, in an attempt to relieve {His/Her:his} pain and discomfort and allow {His/Her:his} to pursue normal activities.

Should you have any further questions in this matter, please do not hesitate to contact me.

Sincerely,

{Physician/PA List:Thomas S. Smith, M.D...}

FIG. 18

{Miscellaneous:Today's Date}

RE: {Patient:, {Patient:First Name}

{Ref. Doctor:First Name} {Ref. Doctor:Last Name}
{Ref. Doctor:Addressl}
{Ref. Doctor:City}, {Ref. Doctor:State} {Ref. Doctor:Zip Code}

Dear Dr. {Ref Doctor:Last Name}:

I had the pleasure of seeing your patient, {Patient:First Name} {Patient:Last Name} for an orthopaedic consultation.

Briefly, the clinical evaluation showed that the patient has

My plan is to

Enclosed is a copy of my evaluation. As always, I will keep you informed of your patient's progress.

Thank you for allowing me to share in the care of this pleasant individual.

Sincerely Yours,

{PhysicianlPA List:Thomas S. Smith, M.D...}

FIG. 19

LVBMJ X-RAY REPORT

PATIENT NAME: {Patient:Last Name}, {Patient:First Name} {Patient:Middle Initial}
DATE OF BIRTH: {Patient:Birth Date}
TYPE OF STUDY: X-Ray

REPORT:

{Miscellaneous:Free Form} views of the {Miscellaneous:Free Form} were obtained and read from an Orthopaedic standpoint. Soft tissues did no show any calcification. No metastatic lesions were noted. {Miscellaneous:Free Form}

IMPRESSION:
{Miscellaneous:Free Form}

Read by {Physician/PA List:Thomas S. Sauer, M.D...}

FIG. 20